

<i>SERFF Tracking Number:</i>	<i>WKLY-125841341</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shenandoah Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40416</i>
<i>Company Tracking Number:</i>	<i>SH 2009 OC</i>		
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>
<i>Product Name:</i>	<i>Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Shenandoah Life Insurance Company

Product Name: Shenandoah Life Insurance SERFF Tr Num: WKLY-125841341 State: ArkansasLH

Company 2009 Outline of Medicare

Supplement Coverage Filing

TOI: MS06 Medicare Supplement - Other

SERFF Status: Closed

State Tr Num: 40416

Sub-TOI: MS06.000 Medicare Supplement - Other

Co Tr Num: SH 2009 OC

State Status: Filed-Closed

Filing Type: Form

Co Status:

Reviewer(s): Stephanie Fowler

Author: Jeffrey McGinn

Disposition Date: 11/03/2008

Date Submitted: 10/02/2008

Disposition Status: Filed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/03/2008

State Status Changed: 11/03/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The attached outline of coverage has been revised to comply with the 2009 Medicare Supplement Deductibles and Copayments. It replaces MS-OC 1-08 AR.

This outline will be used with policy form numbers MS-AA 5-06 AR et al. These policy forms were approved by your Department on April 25, 2006.

SERFF Tracking Number: WKLY-125841341 State: Arkansas
Filing Company: Shenandoah Life Insurance Company State Tracking Number: 40416
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TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing
Project Name/Number: /

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAI01)

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Wakely and Associates, Inc. (727) 584-8128 [Phone]
Largo, FL 33773-1502 (727) 584-5613[FAX]

Filing Company Information

Shenandoah Life Insurance Company	CoCode: 68845	State of Domicile: Virginia
2301 Brambleton Ave SW	Group Code: 891	Company Type: Life and Health
		Insurer
Roanoke, VA 24025	Group Name:	State ID Number:
(540) 985-4400 ext. [Phone]	FEIN Number: 54-0377280	

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shenandoah Life Insurance Company	\$20.00	10/02/2008	22871481

SERFF Tracking Number: *WKLY-125841341* *State:* *Arkansas*
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TOI: *MS06 Medicare Supplement - Other* *Sub-TOI:* *MS06.000 Medicare Supplement - Other*
Product Name: *Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing*
Project Name/Number: */*

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	11/03/2008	11/03/2008

SERFF Tracking Number: *WKLY-125841341* *State:* *Arkansas*
Filing Company: *Shenandoah Life Insurance Company* *State Tracking Number:* *40416*
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TOI: *MS06 Medicare Supplement - Other* *Sub-TOI:* *MS06.000 Medicare Supplement - Other*
Product Name: *Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing*
Project Name/Number: */*

Disposition

Disposition Date: 11/03/2008

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WKLY-125841341 State: Arkansas

Filing Company: Shenandoah Life Insurance Company State Tracking Number: 40416

Company Tracking Number: SH 2009 OC

TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing

Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	Yes
Supporting Document	Third Party Authorization Letter	Accepted for Informational Purposes	Yes
Form	Outline of Medicare Supplement Coverage	Filed	Yes

SERFF Tracking Number: WKLY-125841341 State: Arkansas

Filing Company: Shenandoah Life Insurance Company State Tracking Number: 40416

Company Tracking Number: SH 2009 OC

TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing

Project Name/Number: /

Form Schedule

Lead Form Number: MS-OC 1-09 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed	MS-OC 1-09 AR	Outline of Coverage	Outline of Medicare Supplement Coverage	Revised	Replaced Form #: MS-OC 1-08 AR Previous Filing #: 37173		MS-OC 1-09 AR.pdf

◆ ROANOKE, VIRGINIA 24029 ◆

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, C, D, E, F AND G

These charts show the benefits included in each Medicare supplement plan. Every company must make available Plan “A”. Some plans may not be available in your state.

See Outlines of Coverage sections for details on ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign emergency deductible.

Outline of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit ***	\$2310 Out of Policy Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exceptions.

SHENANDOAH LIFE INSURANCE COMPANY

For Use in Arkansas Zip Codes 720-722

ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
1,631.00	1,812.00	2,054.00	2,282.00	2,281.00	2,534.00	2,075.00	2,304.00	2,093.00	2,326.00	2,339.00	2,599.00	2,122.00	2,358.00

SEMI-ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
815.50	906.00	1,027.00	1,141.00	1,140.50	1,267.00	1,037.50	1,152.00	1,046.50	1,163.00	1,169.50	1,299.50	1,061.00	1,179.00

QUARTERLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
407.75	453.00	513.50	570.50	570.25	633.50	518.75	576.00	523.25	581.50	584.75	649.75	530.50	589.50

MONTHLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
135.92	151.00	171.17	190.17	190.08	211.17	172.92	192.00	174.42	193.83	194.92	216.58	176.83	196.50

SHENANDOAH LIFE INSURANCE COMPANY

For Use in Arkansas Zip Codes 718, 719

ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
1,495.00	1,661.00	1,883.00	2,092.00	2,091.00	2,323.00	1,902.00	2,112.00	1,918.00	2,132.00	2,144.00	2,383.00	1,945.00	2,162.00

SEMI-ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
747.50	830.50	941.50	1,046.00	1,045.50	1,161.50	951.00	1,056.00	959.00	1,066.00	1,072.00	1,191.50	972.50	1,081.00

QUARTERLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
373.75	415.25	470.75	523.00	522.75	580.75	475.50	528.00	479.50	533.00	536.00	595.75	486.25	540.50

MONTHLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
124.58	138.42	156.92	174.33	174.25	193.58	158.50	176.00	159.83	177.67	178.67	198.58	162.08	180.17

SHENANDOAH LIFE INSURANCE COMPANY

For Use in Arkansas Zip Codes All Except 718-722

ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
1,223.00	1,359.00	1,541.00	1,712.00	1,711.00	1,901.00	1,556.00	1,728.00	1,570.00	1,744.00	1,754.00	1,949.00	1,591.00	1,769.00

SEMI-ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
611.50	679.50	770.50	856.00	855.50	950.50	778.00	864.00	785.00	872.00	877.00	974.50	795.50	884.50

QUARTERLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
305.75	339.75	385.25	428.00	427.75	475.25	389.00	432.00	392.50	436.00	438.50	487.25	397.75	442.25

MONTHLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
101.92	113.25	128.42	142.67	142.58	158.42	129.67	144.00	130.83	145.33	146.17	162.42	132.58	147.42

PREMIUM INFORMATION

Shenandoah Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

Premiums will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Administrative Office at P.O. Box 10855, Clearwater, Florida 33757-8855. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Shenandoah Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$0 \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$1068 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B deductible) \$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$135 (Part B deductible) \$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum.
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PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	\$0	\$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

PLAN E

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment	 100%	 \$0	 \$0
First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 80%	\$0 20%	\$135 (Part B deductible) \$0

(continued)

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First 250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000.	 \$250 20% and amounts over the \$50,000 lifetime maximum.
*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	 \$0 \$0	 \$120 \$0	 \$0 All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$135 (Part B deductible) Generally 20%	 \$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	\$0	\$1600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum

<i>SERFF Tracking Number:</i>	<i>WKLY-125841341</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Shenandoah Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>40416</i>
<i>Company Tracking Number:</i>	<i>SH 2009 OC</i>		
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>
<i>Product Name:</i>	<i>Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: WKLY-125841341 State: Arkansas
Filing Company: Shenandoah Life Insurance Company State Tracking Number: 40416
Company Tracking Number: SH 2009 OC
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Shenandoah Life Insurance Company 2009 Outline of Medicare Supplement Coverage Filing
Project Name/Number: /

Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice 10/02/2008
Bypass Reason: N/A. Only filing the outline of coverage.
Comments:

Review Status:

Bypassed -Name: Application 10/02/2008
Bypass Reason: Outline of Coverage filing only.
Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification 10/02/2008
Bypass Reason: Outline of Coverage filing only.
Comments:

Review Status:

Satisfied -Name: Outline of Coverage Accepted for Informational Purposes 11/03/2008
Comments:
Attachment:
MS-OC 1-09 AR.pdf

Review Status:

Satisfied -Name: Third Party Authorization Letter Accepted for Informational Purposes 11/03/2008
Comments:
Attachment:
2008 07 SH Authorization Letter.pdf

◆ ROANOKE, VIRGINIA 24029 ◆

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, C, D, E, F AND G

These charts show the benefits included in each Medicare supplement plan. Every company must make available Plan “A”. Some plans may not be available in your state.

See Outlines of Coverage sections for details on ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign emergency deductible.

Outline of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit ***	\$2310 Out of Policy Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

***** The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exceptions.

SHENANDOAH LIFE INSURANCE COMPANY

For Use in Arkansas Zip Codes 720-722

ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
1,631.00	1,812.00	2,054.00	2,282.00	2,281.00	2,534.00	2,075.00	2,304.00	2,093.00	2,326.00	2,339.00	2,599.00	2,122.00	2,358.00

SEMI-ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
815.50	906.00	1,027.00	1,141.00	1,140.50	1,267.00	1,037.50	1,152.00	1,046.50	1,163.00	1,169.50	1,299.50	1,061.00	1,179.00

QUARTERLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
407.75	453.00	513.50	570.50	570.25	633.50	518.75	576.00	523.25	581.50	584.75	649.75	530.50	589.50

MONTHLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
135.92	151.00	171.17	190.17	190.08	211.17	172.92	192.00	174.42	193.83	194.92	216.58	176.83	196.50

SHENANDOAH LIFE INSURANCE COMPANY

For Use in Arkansas Zip Codes 718, 719

ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
1,495.00	1,661.00	1,883.00	2,092.00	2,091.00	2,323.00	1,902.00	2,112.00	1,918.00	2,132.00	2,144.00	2,383.00	1,945.00	2,162.00

SEMI-ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
747.50	830.50	941.50	1,046.00	1,045.50	1,161.50	951.00	1,056.00	959.00	1,066.00	1,072.00	1,191.50	972.50	1,081.00

QUARTERLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
373.75	415.25	470.75	523.00	522.75	580.75	475.50	528.00	479.50	533.00	536.00	595.75	486.25	540.50

MONTHLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
124.58	138.42	156.92	174.33	174.25	193.58	158.50	176.00	159.83	177.67	178.67	198.58	162.08	180.17

SHENANDOAH LIFE INSURANCE COMPANY

For Use in Arkansas Zip Codes All Except 718-722

ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
1,223.00	1,359.00	1,541.00	1,712.00	1,711.00	1,901.00	1,556.00	1,728.00	1,570.00	1,744.00	1,754.00	1,949.00	1,591.00	1,769.00

SEMI-ANNUAL RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
611.50	679.50	770.50	856.00	855.50	950.50	778.00	864.00	785.00	872.00	877.00	974.50	795.50	884.50

QUARTERLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
305.75	339.75	385.25	428.00	427.75	475.25	389.00	432.00	392.50	436.00	438.50	487.25	397.75	442.25

MONTHLY RATES

Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker	N on-Smoker	Smoker
101.92	113.25	128.42	142.67	142.58	158.42	129.67	144.00	130.83	145.33	146.17	162.42	132.58	147.42

PREMIUM INFORMATION

Shenandoah Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

Premiums will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Administrative Office at P.O. Box 10855, Clearwater, Florida 33757-8855. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Shenandoah Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$0 \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$1068 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B deductible) \$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$135 (Part B deductible) \$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$135 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$135 (Part B deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum.
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PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	\$0	\$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

PLAN E

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$135 (Part B deductible) \$0
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(continued)

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First 250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000.	 \$250 20% and amounts over the \$50,000 lifetime maximum.
*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	 \$0 \$0	 \$120 \$0	 \$0 All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$135 (Part B deductible) Generally 20%	 \$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	\$0	\$1600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum



SHENANDOAH LIFE INSURANCE COMPANY

Kathleen M. Kronau
Vice President, General Counsel & Secretary

Office: 800-848-5433, Ext. 4226
Fax: 540-857-5916
Email: kathleen.kronau@shenlife.com

July 22, 2008

Ms. Darcey Shaffer
Compliance Manager
Wakely & Associates, Inc.
8545 126th Ave. North, Suite 200
Largo, Florida 33773-1502

Re: Authorization Letter to File Medicare Supplement Forms and Rates

Dear Ms. Shaffer:

This letter authorizes Wakely and Associates, Inc. to file Shenandoah Life Insurance Company's Medicare Supplement forms and rates with State Insurance Departments. Also, Wakely and Associates, Inc. may correspond with the State Insurance Departments regarding any questions they may have concerning such filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely yours,

Kathleen M. Kronau
Vice President, General Counsel & Secretary